### PRINTED: 07/25/2008 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 09G192 07/16/2008 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3312 4TH STREET, SE IDI WASHINGTON, DC 20032 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) W 000 l **INITIAL COMMENTS** W 000 On July 2, 2008 at approximately 12:21 PM the State Agency (SA) was notified via facsimile of an Unusual Incident Report (UIR) from the facility that revealed on June 30, 2008, the incident Management Coordinator (IMC) was informed that Active Treatment Specialists (ATS) #1 accepted 3/ 40/0 witnessed ATS #2 "inappropriatly playing" with Client #1 by playfully hitting him with a placemat GOVERNMENT OF THE DISTRICT OF COLUMBIA on June 23, 2008. DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION The SA conducted an on-site investigation on July 825 NORTH CAPITOL ST., N.E., 2ND FLOOR 10, 2008 to verify compliance with the basic WASHINGTON, D.C. 20002 standards of practice and federal requirements in Governing Body and Client Protection. The investigation determined that ATS #2 was placed on administrative leave on July 1, 2008. The investigation also determined that the Qualified Mental Retardation Professional (QMRP) was placed on administrative leave on July 1, 2008. The results of the investigation were based on interviews with ATS and administrative staff. Also the findings were based on the review of the client's medical record, and the facility's administrative records; including incident reports. W 104 483.410(a)(1) GOVERNING BODY W 104 The governing body must exercise general policy, budget, and operating direction over the facility

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

This STANDARD is not met as evidenced by: Based on interview and record review, the governing body exercised general policy and operating direction over the facility, except in the

TITLE ADRI

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days wing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 program participation.

following areas:

		I AND HUMAN SERVICES & MEDICAID SERVICES			FORM	07/25/2008 APPROVED
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL	LE CONSTRUCTION	OMB NO. (X3) DATE SI COMPLE	0938-0391 JRVEY ITED
	<u></u>	09G192	B. WING		ı	C 6/2008
IDI	ROVIDER OR SUPPLIER		334	EET ADDRESS, CITY, STATE, ZIP CODE 12 4TH STREET, SE ASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP	OULD BE	(X5) COMPLETION DATE
	to provide sufficier ensure the implemmanagement policiallegations of abust administrator.  2. Cross refer to W to provide sufficier ensure the implem and procedures for between staff and 483.420(d)(1) STACLIENTS  The facility must of policies and procedures and procedures and procedures for consistreatment, negocial to the staff failed management profits written policies management of consure its incider implemented investigation (Clients written policies management of consure its incider implemented investigation incider incider implemented investigation incider	de:  2153. The governing body failed in administrative oversight to inentation of its incident by involving reporting all se immediately to the  2267. The governing body failed introduction of its written policies or the management of conduct clients.  AFF TREATMENT OF  develop and implement written edures that prohibit glect or abuse of the client.  is not met as evidenced by: we and record review, the sed to implement it's incident tocol for one of one client in the ent #1) and failed to implement and procedures for the conduct between staff and clients ent in the investigation. (Client	W 104	W104 This standard will be met a Evidenced by:  Review of record indicates that facility currently has written purcedures regarding abuse/mistreatment.  A team efforts has been utilized senior management (Director Residential Services, Director nursing, RN and Training Department) to retrain all in the abuse/neglect, incident report documentation and programm. The facility will ensure that all are reported to pertinent agency/management in accordistrict law and that confirmate is file on client record/inciden book.  The facility management/Trained department will continue to train on-going basis and will enincident of abuse/neglect or mistreatment are thoroughly investigated in accordance we standard. Any employee that comply with this standard as will be subject to disciplinary.  Cross reference W153  Cross reference W2	s  at The collicies and reglect and reglec	7/10/2008

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

A BUILDING

(X2) MULTIPLE CONSTRUCTION

A BUILDING

C

(X3) DATE SURVEY COMPLETED

C

<del>-</del>		09G192	B. Wit	1G		07/1	6/2008
NAME OF PI	ROVIDER OR SUPPLIER		<del>'</del>	STRE	ET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	012000
IDI				33.	12 4TH STREET, SE ASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	SHOULD BE COM	
PREFIX	Continued From page 2. Cross refer to Wiensure its ensure it procedures for the between staff and staff. 483.420(d)(2) STACLIENTS  The facility must emistreatment, neglinjuries of unknow immediately to the officials in accordate stablished procedures to ensure the reported immediately to the reported immediately to the facility of the continuence of the stablished procedures and government and	region of the facility staff failed to a service of the facility of the facility at all allegations of a source, are reported administrator or to other and ince with State law through dures.  Is not roet as evidenced by: It want record review the facility at all allegations of abuse are tely to facility's administrator agencies as required by DC CMR Chapter 35 Section  ES:  FC on July 10, 2008 at 5PM revealed that on June 24, it Mental Retardation	PREF TAC		(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI	JLD BE OPRIATE  facility dures usly ished. as been ard. ue to	COMPLETION DATE  7/18//2008
	Professional (QM Department of Dinformed him of a abuse at the facily stated that she with e was during an revealed that on their that she wither	RP) informed her that the sability Services (DDS) had in anonymous allegation of ity on June 23, 2008. The FC as informed by the QMRP that internal investigation. The FC June 26, 2008, ATS #1 informed assed ATS #2 "inappropriately int #1 by playfully hitting him with					

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 07/25/2008 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 09G192 07/16/2008 ME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3312 4TH STREET, SE LDI WASHINGTON, DC 20032 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY W 153 Continued From page 3 W 153 a cotton placemat on June 23, 2008. The FC W153 revealed that she immediately informed the This Standard will be met as QMRP who informed her that he would notify the 7/25/08 Evidenced by: administrators and other officials. Review of record noted that the QMRP received training on policies and Interview with the IMC on July 14, 2008 at procedures as related to incident approximately 10:00 AM revealed that while reporting/incident investigation as part reviewing the MRDDA Consumer Information of the orientation to the agency and System(MCIS) on June 30, 2008, it was including DDS incident management discovered that there were several rejected training. The QMRP no longer work for the incidents of allegations of abuse at the facility. agency. The IMC telephoned the QMRP on that same day All staff has been re-trained on abuse, in order to ascertain what he knew about the neglect and mistreatment. In future, the rejected incidents of allegations of abuse at the Training department will complete a periodic audit/monitoring of facility facility, however he did not respond. On July 1, training book to ensure that all employee 2008, the IMC did an on-site visit to the facility continue to receive on-going training on and was informed by the QMRP that DDS had incident reporting, abuse/neglect, client informed him on either June 24 or June 25, 2008 right/sensitivity in compliance with the policy and procedure. of an allegation of abuse that occurred at the facility on June 23, 2008. The IMC stated that the QMRP informed her that he was during an internal investigation, however he had not informed the facility administrator of the allegation of abuse. Interview with the QMRP on July 23, 2008 at

approximately 10:15AM revealed that on June 24, 2008, DDS had informed him of an anonymous allegation of abuse involving unknown clients at the facility on June 23, 2008. The QMRP revealed that on June 26, 2008, the FC informed him that ATS #1 witnessed ATS #2 "inappropriately playing" with Client #1 by playfully hitting him with a cotton placemat on June 23, 2008. The QMRP revealed that he had not informed the facility administrator. Further interview with the QMRP revealed that he had not informed the facility administrator of the allegation of abuse that had been reported by DDS or the Department of

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/25/2006 FORM APPROVED OMB NO. 0938-0391

	F CORRECTION	IDENTIFICATION NUMBER;	A. BUILD		(X3) DATE SU	ED
		09G192	B. MING		07/16	/2008_
IDI	ROVIDER OR SUPPLIE	2		STREET ADDRESS, CITY, STATE, ZIP CODE 3312 4TH STREET, SE WASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE AP DEFICIENCY)	HÔULD BÉ	(X5) COMPLETION DATE
W 153	Health (DOH).  Review of the Induly 1, 2003 on 4:40 PM reveale witnesses, disconding the immediate shacility staff on disconding the immediate shacility staff on disconding the facility's admitted the immediately repeting the facility's admitted the integrated, coordinated the immediated mental (QMRP) failed and coordinate eight of eight coordinate eight allegating the finding income the find	cident Management Policy dated July 14, 2008 at approximately d that "any person who vers or is informed of a Serious ent as defined by this policy, ly verbally report the incident to upervisor/manager on duty. The uty will accept reports of Serious lents, on a 24 hour, 7 days a vidence that the facility's QMRP orted an allegation of abuse to ninistrator and DOH. ALIFIED MENTAL I PROFESSIONAL tive treatment program must be edinated and monitored by a I retardation professional.  RD is not met as evidenced by: view, and record review, the all Retardation Professional to adequately monitor, integrate, the health and safety needs for lients in the facility. (Client #1, at #3, Client #4, Client #5, Client and Client #8)				7/25/2008

#### PRINTED: 07/25/2008 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 **\$TATEMENT OF DEFICIENCIES** (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING C B. WING \_ 09G192 07/16/2008 .ME OF PROVIDER OR SUPPLIER

"ME OF PRO	OVIDER OR SUPPLIER	s	TREET ADDRESS, CITY, STATE, ZIP CODE
IDI			3312 4TH STREET, SE WASHINGTON, DC 20032
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (X5)  COMPLETION DATE
W 189	483.430(e)(1) STAFF TRAINING PROGRAM	W 18	9
	The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.		W189 This standard will be met as evidenced by:
	This STANDARD is not met as evidenced by: Based on staff interviews and record reviews, the facility failed to ensure that each employee had been provided with adequate training that enables the employee to perform his or her duties effectively, efficiently and competently.		Cross Reference W153 Cross Reference W267
	The findings include:		
	Cross Refer to W153. The facility failed to ensure that the staff had received effective training on implementing the facility's incident management policy related to reporting allegations of abuse immediately to facility's administrator and government agencies.		
	2. Cross Refer to W267. The facility staff failed to ensure that the staff received effective training in implementing the written policies and procedures for the management of conduct between staff and clients for Client #1.		
W 267	483.450(a)(1) CONDUCT TOWARD CLIENT  The facility must develop and implement written policies and procedures for the management of conduct between staff and clients.	W 2	267
	This STANDARD is not met as evidenced by: Based on interview, the facility failed to ensure that written policies and procedures for the management of conduct between staff and clients		
EODM ONE	2567(02-99) Previous Versions Obsolete Event ID: EWIM		Feditiv ID-00C404

## DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 07/25/2008 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B, WING 09G192 07/16/2008 ... JME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3312 4TH STREET, SE IDI WASHINGTON, DC 20032 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION PRÉFIX (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX COMPLÉTION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY W 267 Continued From page 6 W 267 were implemented by all staff, for one of the one client in the investigation. (Client #1) The finding includes: On July 2, 2008 at approximately 12:21 PM the State Agency (SA) was notified via facsimile of an Unusual Incident Report (UIR) from the facility that revealed that on June 30, 2008, the Incident Management Coordinator (IMC) was informed that Active Treatment Specialists (ATS) #1 witnessed ATS #2 "inappropriatly playing" with Client #1 by playfully hitting him with a cotton placemat on June 23, 2008. Interview with ATS #1 on July 10, 2008 at approximately 2:45PM revealed that she witnessed ATS #2, "inappropriately playing" with Client #1 by playfully hitting him with a cotton placemat on June 23, 2008. Interview with the ATS #2 on July 14, 2008 at approximately 9:10 AM revealed that on one

they both laughed.

evening that she was asked to work(date

#2 stated that she then rolled up a cotton

unknow), Client #1 "was rnaking hand gestures to say that he [Client #1] was going to hit me in the eye, I told him [Client #1] that if he didn't stop he was going to get a beating and he started

laughing out loud and rolling his eyes at me and I stated rolling my eyes, and we both started laughing." Further interview revealed that Client #1 started making hand gestures again and ATS

placemat and "tapped" Client #1 on the legs and

Interview with the ATS #3 on July 14, 2008 at approximately 9:40 AM revealed that on one evening that ATS #2 worked with him (date

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/25/2008 FORM APPROVED OMB NO. 0938-0391

STATEMEN"	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(Y2) 1	du stes	N. C. COURTE	OMB NO.	0938-0391
AND PLAN (	ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			RV <b>E</b> Y FED
		09G192	B. WI	1G		27/10	1
ME OF F	PROVIDER OR SUPPLIER			33	EET ADDRESS, CITY, STATE, ZIP CODE 312 4TH STREET, SE /ASHINGTON, DC 20032	07/16	/2008
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG	ix	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	ULDBE	(XS) COMPLETION DATE
W 267	unknown), he obse hand toward Client made contact with interview revealed above as an incide ATS #2 and Client Review of the writt protect clients' digrat approximately 5 and supports will in courteous, respect individual and facil understanding of where was no evid procedures for the	wed ATS #2 " waving her #1, but was not sure if ATS #2 Client #1's body. Further that ATS #3 did not report the nt because " I thought that #1 were playing".  The policies and procedures to nity and rights on July 21, 2008 is 30PM revealed that " services nolude communications that are ful of the dignity of the	W	267	W267 This Standard will be met a Evidenced by:  Disciplinary action has been to ATS #2 for failure to follow policies and procedures as we all staff has been retrained orights, abuse/neglect and click sensitivity.  The facility management will continue an on-going training conduct and sensitivity to individuals in accordance with written policies and procedure. Evidence of such training will in the training book.	given  ow  ritten.  on client  ent  g of	7/25/2008

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIE IDENTIFICATION NU  HFD03-0050		R/CLIA MBER;	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED C	
			RESS. CITY, S	STATE, ZIP CODE	07/16/2008	
IDI			3312 4TH	STREET, SE	<u>.</u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY LSC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE COMPLETE
1 000	INITIAL COMMEN	NTS		1000		
	State Agency (SA Unusual Incident that revealed that Management Coot that Active Treatm witnessed ATS # Resident #1 by pl placemat on June The SA conducted July 10, 2008 to with the SA conducted July 10, 2008 to w	ed an on-site investigaterify cornpliance with effice and federal requiand Client Protection. From the that ATS #2 volume is the condition of the the condition of the the condition Professional (QMR is trative leave on July investigation were based on the real record, and the faci cords; including incide ENCIES	elimile of an a facility in Incident formed and inciden	1 379	GOVERNMENT OF THE DISTRICT OF DEPARTMENT OF HEAL HEALTH REGULATION ADMINISTS NORTH CAPITOL ST., N.E., 2000	TH STRATION 2ND FLOOR
	each GHMRP shall notify the Department of Health, Health Facilities Division of any other unusual incident or event which substantially interferes with a resident 's health, welfare, living arrangement, well being or in any other way places the resident at risk. Such notification shall be made by telephone immediately and shall be followed up by written notification within twenty-four (24) hours or the next work day.					
	lation Administration	OVIDER/SUPPLIER REPRES	SENTATIVE'S SI	GNATURE	TITLE A	2.5 (XE) DATE

`TE FORM

PRINTED: 07/25/2008 FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIE IDENTIFICATION NU  HFD03-0050		R/CLIA MBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED C		
ME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, ST	ATE, ZIP CODE	0771	0/2000
IDI				STREET, SE TON, DC 200	032		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY I LSC IDENTIFYING INFORM	CFULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENT	NON SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
l 379	Continued From p	page 1		l 379		,	
	GHMRP shall not Health Facilities I incident or event with a resident 's arrangement, we places the reside be made by telepfollowed up by with the special with the approximately 3: 2008 the Qualified Professional (QID Department of Dinformed him of abuse at the fact stated that she was during a revealed that or her that she with playing" with Rewith a cotton playing with Rewith a cotton playing with a cotton playing with a cotton playing with Rewith a cotton playing with Rewith a cotton playing with a	ot met as evidenced be tify the Department of Division of any other use which substantially into the health, welfare, living all being or in any other that risk. Such notification within hours or the next work des:  The FC on July 10, 2008 and 15PM revealed that one defended that one defended the properties of the provided that one and other all reverses (DD and an anonymous allegations of June 26, 2008, ATS increased ATS #2 "inapposition of June 26, 2008, ATS increased ATS #2 "inapposition of June 26, 2008, and other officials.  The IMC on July 14, 2008 and other officials.  The IMC on July 14, 2008 and other officials.  The IMC on July 14, 2008 and other officials.  The IMC on July 14, 2008 and other officials.  The IMC on July 14, 2008 and other officials.  The IMC on July 14, 2008 and other officials.  The IMC on July 14, 2008 and other officials.  The IMC on July 14, 2008 and other officials.  The IMC on July 14, 2008 and other officials.  The IMC on July 14, 2008 and other officials.  The IMC on July 14, 2008 and other officials.  The IMC on July 14, 2008 and other officials.  The IMC on July 14, 2008 and other officials.  The IMC on July 14, 2008 and other officials.	Health, inusual terferes or way cation shall be in a common day.  The FC of the FC of the FC of the FC of the Id notify the same day of the facility of the fa				

EWIM11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLII IDENTIFICATION NU			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(EX) DATE SI	TED	
HFD03-0050				B. WING	B. WING		6/2008
NAME OF PROVIDER OR SUPPLIER ST				RESS, CITY, ST	ATE, ZIP CODE		
IDI				STREET, SE FON, DC 200	32		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY R LSC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT. CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
1 379	Continued From	page 2		1 379			
	rejected incidents facility, however 2008, the IMC diand was informed informed him on of an allegation of facility on June 2 QMRP informed internal investigation of abuse.  Interview with the approximately 1'2008, DDS had allegation of abuse that facility on June 23, 2008, not informed the facility hitting I June 23, 2008, not informed the interview with the informed the facility of abuse that he Department of Review of the I July 1, 2003 on 4:40 PM reveal witnesses, discontinust immediate facility staff on Reportable Incomes basis."	s of allegations of abushe did not respond. Or d an on-site visit to the d by the QMRP that the either June 24 or June of abuse that occurred 23, 2008. The IMC stather that he was during ation, however he had allity administrator of the informed him of an analese involving unknown are 23, 2008. The QMRP are alled that a line informed him of an analese involving unknown are 23, 2008. The QMRP are alled the facility administrator. The QMRP revealed the facility administrator of the informed him with a cotton place. The QMRP revealed the facility administrator of the domain and been reported by Directly administrator of the domain and been reported by Directly administrator of the domain and been reported by Directly administrator of the domain and been reported by Directly and the proposed of the informed or info	n July 1, a facility he DDS at the ted that the gan not e allegation 008 at con June 24, onymous clients at RP conformed at the had not he allegation DS or the policy dated eximately no fa Serious incident to n duty. The sof Serious days a				
	There was no	evidence that the facili	ty's QMRP	1			

PRINTED: 07/25/2008 FORM APPROVED

			<del></del>				
	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIE IDENTIFICATION NUI		R/CLIA MBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED C	
NE OF D	ROVIDER OR SUPPLIER	1 17000-0000	STREET AD	DRESS CITY S	TATE, ZIP CODE	07/1	6/2008
IDI	ROVIDER OR SUPPLIER		3312 4TH	STREET, SE GTON, DC 20			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY LSC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
1 379	immediately repor	age 3 ted an allegation of a listrator and governm		1379	3519.10 This Statue will be me evidenced by: Reference W104, W14 And W267		7/10/2008